STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185095	A. BUILDING _____ B. WING _____	C 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HILLCREEK	3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220

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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 01/15/15 and concluded on 01/16/15 to investigate KY 22707 and KY22695. The Division of Health Care substantiated the allegation with a deficiency cited for KY22707 and unsubstantiated the allegation with no deficiencies for KY22695.	F 000		
F 203	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/27/2015

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F 203	Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to provide written notification of transfer/discharge to one (1) of six (6) sampled residents, Resident #4. The facility transferred Resident #4 to a local hospital on 01/15/15 and did not provide written notification of the transfer and discharge to the resident or Guardian, which would have included the reason for discharge, and contact agencies if the Guardian wanted to appeal the transfer or discharge. The findings include: Review of the facility's policy Resident Rights, Transfers and Discharges, revised October 2009,	F 203		

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revealed written notification would be provided to the resident, family or Guardian prior to transfer and would include the reason for the transfer, the date of the transfer, location of transfer, explanation of right to appeal, and the name, address, and telephone number for the Ombudsman and other agencies as required by the state. Additionally, the written notice would follow verbal notification for unplanned acute transfers.

Review of the facility's Transfer/Discharge Policy, not dated, revealed each resident would be permitted to remain in the facility and not be transferred or discharged unless: it was necessary for the resident's welfare; the resident's health had improved so that services were no longer needed; the safety or health of residents were endangered; the resident failed to pay for services; the facility ceased to operate;, and, the resident or Guardian wished for a discharge. Additionally, in the event a resident was transferred or discharged the facility would give written notice of the reason for transfer or discharge to the resident, family or legal guardian.

Review of the facility's Notice of Proposed Transfer/Discharge, dated August 1996, revealed the form included the reason for, and date of, transfer/discharge, and where the resident would be transferred/discharged.

Review of the facility's list of discharged residents revealed Resident #4 had been discharged from the facility 1/15/15 at 10:57 PM.

The facility did not provide evidence that a written Notice of Transfer/Discharge was completed

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when the facility discharged the resident to a local hospital on 01/15/15.

Review of Resident #4's clinical record revealed the resident was admitted from a local hospital. The hospital discharge summary, dated 01/07/15, revealed diagnoses which included Seizure Disorder and Pseudoseizures. The Pseudoseizures began after the resident had become stressed with a family situation. Psychiatry determined the change in the resident's seizure activity was a reaction to current stressors and was a way for the resident to cope. However, after staff interacted with the resident, he/she had not had a pseudoseizure in the last two (2) weeks. The hospital noted the Pseudoseizures would likely begin again with a change in environment.

Review of the clinical record for Resident #4 revealed the facility admitted the resident on 01/07/15 with diagnoses of Epilepsy and Anxiety. A nurse's note on 01/13/15 at 8:07 AM, stated the resident had transferred to a local hospital due to seizure activity and returned later the same day. On 01/13/15 at 10:38 PM, the resident was found rocking back and forth for fifty-four (54) minutes and was sent to the hospital. On 01/14/15 at 3:26 PM, a nurse's note indicated Resident #4 displayed seizure like activity, rocking back and forth, for about an hour, and later began the seizure like activity again. The resident was sent to the hospital and returned later the same day.

A nurse's note, on 01/15/15 at 6:30 AM, stated the resident was discovered rocking side to side and was sent to the hospital. A Nurse's note, dated 01/15/15 at 2:14 PM, explained the resident had symptoms of a pseudoseizure followed by a

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three (3) hour tantrum that ended when the Nurse Practitioner (NP) saw the resident. On 01/15/15 at 4:00 PM, the NP's note stated the resident had been yelling out and staff were unable to calm the resident. No danger was noted to the resident.

On 01/15/15 at 4:30 PM, a nurse's note stated the facility administered Ativan 0.5 mg intramuscular (IM) per the physician, and if the Ativan was ineffective the facility should transfer the resident to the hospital for a psychiatric evaluation. A follow up Nurse's note, on 01/15/15 at 4:44 PM, revealed the Ativan was not effective and the resident would be transferred to the hospital for a psychiatric evaluation.

Additionally, the hospital was informed that the facility's Director of Nursing (DON) stated the resident could not return to the facility until his/her behaviors were under control. A Nurse's note, on 01/15/15 at 8:46 PM, stated Resident #4 had stopped yelling out when he/she was placed on the stretcher for transfer to the hospital.

Review of a physician's note, dated 01/15/15, revealed the resident had seizures versus attention/behaviors related to a change in the environment. Nursing would try to engage the resident with activities.

Interview with the Administrator, on 01/16/15 at 2:06 PM, revealed Resident #4 was admitted from the hospital with an agreement between the facility and the hospital for payment. She stated sometimes the resident's from the hospital were sent back to the hospital if the facility felt the resident's placement at the facility was not appropriate. The Administrator stated the resident had been at the facility a few days and then

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began to exhibit seizure activity. She indicated the resident was transferred to the hospital at least twice and returned to the facility each time. She further indicated it was determined the seizure activity was a behavior, pseudoseizures, and the resident began to yell and was disruptive to the other residents. The Administrator stated the facility transferred the resident to the hospital on 01/15/15 and informed the hospital the facility could not accept the resident back.

On 01/16/15 at 3:22 PM, interview with the DON revealed the Notice of Transfer/Discharge form was completed for discharge planning, when a resident went home from the facility. She stated the facility did not have a form for a resident or guardian to sign when transferred from the facility. The DON stated there was no written notice of transfer or discharge for Resident #4.

Interview with the Business Office Manager, on 01/16/15 at 4:12 PM, revealed she was not involved with the written notice of transfer or discharge for residents.

On 01/16/15 at 4:17 PM, interview with the Social Service Nurse revealed when a resident was discharged home she prepared the Notice of Transfer/Discharge for discharge planning. She stated she was unsure if the facility had completed a written Notice of Transfer/Discharge for Resident #4 when the facility discharged the resident on 01/15/15.

Interview, on 01/16/15 at 4:26 PM, with Licensed Practical Nurse (LPN) #3 revealed she completed the transfer of Resident #4 to the hospital for psychiatry on 01/15/15. She stated when she called a report to the hospital, she informed the

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hospital the facility DON stated the facility could not accept the resident back unless the resident's behaviors were under control. The LPN indicated she had not completed the Notice of Transfer/Discharge when the resident left the facility. She further indicated Resident #4 had been screaming and yelling on 01/15/15.

On 01/16/15 at 4:35 PM, interview with the Director of Admissions, revealed the resident was still at the hospital and had not been admitted. She stated the Notice of Transfer/Discharge was completed when a resident was discharged home; however, she was not responsible for the written notification.

Continued interview with the DON, on 01/16/15 at 4:49 PM, revealed on 01/12/15 Resident #4 was transferred to the hospital for seizures, which was thought to be Pseudoseizures. She stated the resident had been transferred to the hospital for pseudoseizures three (3) times. The DON indicated the third time the resident went to the hospital, the hospital determined the resident was at a baseline and did not need to be admitted. The DON stated the resident's behaviors were purposeful, and included pseudoseizures. She indicated on 01/15/15 Resident #4 was screaming, and efforts by the staff to calm the resident were unsuccessful. She stated the resident was sent to the hospital for a psychiatric evaluation. The DON further stated when the resident was placed on the EMS stretcher, the resident began to quiet down. She indicated the resident transferred to the hospital around 5:00 PM, and around 7:00 PM that night, the supervisor at the hospital called to send the resident back. The DON stated she informed the hospital at that time the resident could not return

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to the facility with those behaviors. She indicated the hospital reported the resident was at baseline and there was nothing they could do for him/her. The DON stated she spoke to the hospital's psychiatric physician and Social Worker who reported to her (the DON) that Resident #4 did not meet the criteria for hospitalization and was only having behaviors. She indicated to the DON that Resident #4 was still in the hospital emergency room and would not be admitted, and they had called the facility a couple of times to send the resident back to the facility. The DON further indicated the facility had discharged Resident #4 and the guardian had not been given a written notice of discharge. She stated if the written discharge notice was not given to a resident, family member, or guardian at the time of discharge, then it was possible it could be an inappropriate discharge, She indicated the written notice should be given when the resident left the facility and should be completed by the staff member who discharged the resident or Social Services. The DON stated Resident #4 could not return to the facility unless they could get a guarantee from the hospital that the resident would not scream.

Continued interview with the Administrator, on 01/16/15 at 5:22 PM, revealed Social Services was responsible for completion of the written Notice of Transfer/Discharge. The Administrator stated Resident #4 had been discharged and could not return to the facility. She indicated the hospital had not admitted the resident and had left the resident in the emergency room. The Administrator further indicated the facility did not complete a written Notice of Transfer/Discharge when a resident was sent to the hospital. She stated if a resident was transferred to the hospital

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F 203	Continued From page 8 in an emergency, a written notice was not mailed. The Administrator stated the resident, family or guardian was only given a verbal notification on transfer. She further stated Resident #4's Guardian was given a verbal notification when the resident was sent to the hospital. The Administrator indicated the nurses were not trained to complete the Notice of Transfer/Discharge; however, residents were given a copy of the Transfer/Discharge Policy and Bed Hold Policy when they went to the hospital.	F 203		